

Bobby Jindal
GOVERNOR



Alan Levine
SECRETARY

State of Louisiana
Department of Health and Hospitals
Acadiana Region Supports and Services Center

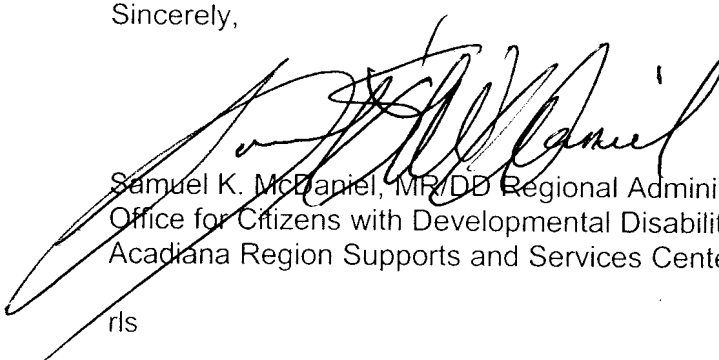
July 7, 2010

DHH/Health Standards Section
Attention: IDR Program Manager
P. O. Box 3767
Baton Rouge, Louisiana 70821-3767

Re: Acadiana Region Supports and Services Center, License #991000057
Survey Response

Enclosed is our Plan of Correction for the survey completed on June 25, 2010. If additional information is needed, please let me know.

Sincerely,



Samuel K. McDaniel, MR/DD Regional Administrator
Office for Citizens with Developmental Disabilities
Acadiana Region Supports and Services Center

rls

enclosure

cc: Greg Andrus (e-mail)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 19G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2010
NAME OF PROVIDER OR SUPPLIER ACADIANA REGION SUPPORTS AND SERVICES CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 GREMILLION CIRCLE IOTA, LA 70543		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 338	<p>483.460(c)(3)(v) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility's nursing services failed to ensure that clients blood tests were done per their physician's orders for 2 of 10 sampled clients. #6, & #10.</p> <p>Findings:</p> <p>1. Client #6 was admitted to the facility on 5-2-1983 with diagnoses which included Moderate Mental Retardation, Seizure Disorder Complex Partial, Gastric Ulcer, COPD and Dysphagia. He was currently being administered Depakote, Prednisolone and Carbatrol on a daily basis</p> <p>Review of his current physician's order dated 6-1-10 read he was to get blood drawn for a CBC, Depakote level, SGPT (ALT) and a Tegretol level every 3 months.</p> <p>Review of his blood test results revealed there were no test results for January, 2010.</p> <p>An interview was held with #S1,DON on 6-23-10 at 11:50 a.m. She reviewed #6's record and stated that his January, 2010 blood tests had not been done. She stated that #6 had been in the hospital in January, 2010 and when he returned to the facility his blood tests had been overlooked.</p> <p>2. Client #10 was admitted to the facility on</p>	W 338	<p>W-338 - The physician will be notified of lab work missed and will provide nursing with instructions regarding the missed lab work. The lab tickler process and the nursing QA system for lab work will be reviewed and revised if needed to prevent future occurrences of missed lab work.</p> <p>Responsible Person: Gale Mello, RN</p>	08/23/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

MR/DD Regional Administrator 7/7/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 338	Continued From page 1 3-6-2006 with diagnoses which included Profound mental retardation, obesity, disruptive behavior disorder, dysphagia, hypothyroidism, anxiety disorder and seizure disorder. In January 2010 she was receiving Synthroid .075 mgm every day for the diagnosis of hypothyroidism. Review of blood test results dated 1/6/2010 revealed an abnormal result for TSH3G (a blood test for thyroid function). A stamp on the bottom of the the laboratory report read "Nurse Review 1/15/10, Physician's Review JAN 21 2010, New Orders Repeat". Further review of the blood test results for TSH3G revealed the next documented test was completed on 5/5/2010. Additional blood test results were in the record dated 2/10/2010 for SGPT, Valproic Acid (Depakene) and a CBC. An interview was held with S1DON on 6/23/10 at 10:50 AM. After the S1DON reviewed #10's record she stated that the blood test ordered by the physician on 1/21/10 had not been repeated as ordered.	W 338			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review on 6/22/10 all drugs administered during a morning drug pass on 6/22/10 were not administered without error for 1 of 3 drug pass clients (#D2). Findings:	W 369	W-369 - An agency incident report will be completed on the drug variance. The physician/APRN will be notified of the drug variance. The CMA will be counseled/trained on the Acadiana Region Supports and Services Center (ARSSC) medication administration protocol. A protocol for using medication from the first dose kit will be developed. The QA system for medication administration will be reviewed and revised if needed to prevent this type of drug variance from occurring in the future. Person Responsible: Gale Mello, RN		08/23/10

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W 369	Continued From page 2 On 6/22/10 during a morning drug pass S3DSW was observed administering medications to D2. S3DSW administered a Cipro 250 mgm tablet at 7:45 AM to that client. Review of the Physician's Orders for 6/1/10 revealed a handwritten order on the side of the Order sheet that read "6/21/2010 Cipro 500 mgm BID x (times) 5 days". The S3DSW was interviewed on 6/23/10 and confirmed that he had only administered one 250 mgm tablet instead of the 2 tablets ordered for the 500 mgm dose.	W 369			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a client with eyeglasses was taught to use and care for his eyeglasses for 1 of 10 sampled clients. #6 Findings: Client #6 was admitted to the facility on 5-2-1983 with diagnoses which included Moderate Mental Retardation, Seizure Disorder, COPD and Dysphagia. He had an annual eye examination on 4-21-10 and was diagnosed with Hyperopia, Presbyopia and Corneal Edema to both eyes and was given a prescription for eyeglasses. According to an Addendum to his ILP dated	W 436	W-436 - Client #6 will be provided with a training objective in the care and maintenance of his eyeglasses. All Clients will continue to have assessments regarding the need for support in using and maintaining of adaptive equipment. Person Responsible: J. Allen Story, Associate to a Psychologist 4	06/30/10	

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NAME OF PROVIDER OR SUPPLIER

ACADIANA REGION SUPPORTS AND SERVICES CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**224 GREMILLION CIRCLE
IOTA, LA 70543**

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W 436	<p>Continued From page 3</p> <p>5-26-10, #6 received his new prescription eyeglasses on 5-25-10. The addendum read that #6 was instructed to be mindful of his glasses and needed to be aware of his responsibility to be gently with his helmet removal due to the risk of bending or breaking his glasses. The addendum read that staff would assist #6 in maintaining proper care of his glasses and that his glasses should be removed each evening before showers, put into his hard case when he was not wearing and kept on top of his wardrobe closet.</p> <p>Review of #6's current training objectives revealed there was no training objective to teach #6 how to use and care for his new eyeglasses.</p> <p>During an interview with #S2,QMRP on 6-23-10 at 1:30 p.m., she confirmed that no training objective had been put in place.</p> <p>During an interview with #S2,QMRP on 6-23-10 at 1:30 p.m., she confirmed that she had not initiated a training objective for #6's new eyeglasses and that he did have a problem with the care of the eyeglasses since he wore a helmet for seizures.</p>	W 436		